



PRESIDENT'S MESSAGE



*by Rodney Nichols, DMD
President 2006-2007*

A few of us who are old enough may remember Yogi Berra of New York Yankee fame. Yogi is now probably more famous for his, “Yogi-isms,” than all of the time he spent behind the plate as a catcher earning three MVP titles, 14 all-star appearances and being voted into the Hall of Fame in 1972.

Yogi-isms are termed malapropisms, referring to a humorous misuse of words. My own favorite yogi-ism is, “If you don’t know where you are going, you will wind up someplace else.” “You can observe a lot just by watching,” is a close second.

Having completed four years on the Board, I have seen a lot just by, “watching.” It certainly does seem like we can end up someplace else when we are not careful about our course and direction. Unfortunately, being held accountable by the Board is not one of the places any of us want to be.

For most of us, our lives continue to be busier and more complicated. We search for ways to meet the, “obligations,” that allow us our lifestyles, and still have, “quality,” time for the people and things that are important to us. These are never ending conflicts that often short change both areas of interest and need, allowing us to end up in places and situations that we did not plan for.

Often, even important things slip by us, like renewing our license to practice. In the most recent renewal cycles, 1,571 Dentists and 1,538

Hygienists renewed their license before it expired. There were also 59 Dentists and 113 Hygienists that renewed after their license had expired (late). Unfortunately, our license is a time-limited document, and when it expires, we are not legally licensed to practice dentistry or dental hygiene in Oregon. To do so without a license is a violation of statute (ORS 679 and 680) and rule (OAR Chapter 818), which govern dentistry and dental hygiene in Oregon.

The yogi-ism that seems to apply to license renewal is, “It’s déjà vu all over again.” In other words, it continues to happen and the excuses seem to be the same, year after year. Yogi also said, “Baseball is 90% mental, the other half is physical.” License renewal is the same, 90% remembering, and the other half getting the renewal to the mailbox.

Another area of difficulty that allows licensees to end up, “someplace else,” is informed consent. OAR 818-012-0070(1)(c) requires that an entry be made in the patient chart that informed consent has been obtained prior to a procedure, any procedure. Informed consent is not just a PARQ/SOAP note or a signed piece of paper, but a process.

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Our Mission: *The mission of the Oregon Board of Dentistry is to assure that the citizens of the state receive the highest possible quality oral health care.*

THEY SAID THE SKY WOULD FALL

Patrick D. Braatz, Executive Director



When I first started as the Board's Executive Director, I was surprised to find out that Board actions taken against a Licensee were not available on the Board's Web site.

At one of my first meetings as Executive Director, I asked the Board for permission to develop a new Licensee look-up system that would provide all of the Board actions that must be released to the public under Oregon Law. The decision from the Board was not unanimous, but the Board gave permission to proceed.

It took a bit longer to have the program developed and work out all of the kinks and along the way, the membership of the Board changed so I once again put the question to them. Again the decision was not unanimous, but the Board supported my recommendation. However, some said this was not going to be good and well the sky might just fall...

In the middle of August of 2006, the Board went live with the new Licensee look-up system. This new system has most of the public information regarding dentists and dental hygienists who have or had a license to practice in this state, along with any official Board action taken regarding that Licensee.

One of the reasons that I wanted to get this system up and running was the pressure from some legislators and public advocacy groups to make the disciplinary information process more public. I was not opposed to such openness, but having an outside group mandating what must be on the system would not be as good as having a system up and running and then being able to show that the system that was in place was working and serving the public.

We have had a very positive response to our Licensee look-up system from consumers, third party-payers, other state boards and Licensees. Yes, there have been a few people who have been critical of the system, but overall the feedback has been positive.

Just to give you an idea about our Web site, during the month of September 2006 we had 43,296 successful hits for the month or 1,464 successful hits per day: in March 2007, we had 55,492 successful hits or 1,790 hits per day.

We have been busy over the past few months with the promulgation of some new rules, amendments and the repeal of some rules that were not needed.

The Oregon Legislature is in session and we have been closely watching any legislation that will affect the OBD and the practice of dentistry and dental hygiene. There will be more new rules that will have to be promulgated based on new bills that have become law.

I am pleased to say the Oregon Legislature did approve the 2007-2009 OBD Budget, the Governor has signed it into law, and that this budget once again does not have any fee increases for Licensees.

We continue to receive very high positive responses from the legislatively mandated customer service survey, ranking in the 85% positives and we continue to meet or exceed the targets of our legislatively approved Performance Measures.

Please feel free to contact me with your questions, concerns or comments at 971-673-3200 or by e-mail at Patrick.Braatz@state.or.us. ■

NEW BOARD MEMBER

Patricia A. Parker, D.M.D., of Albany joined the Board in July of 2006 as a dental member. Dr. Parker was born in Eugene, Oregon. She attended South Eugene High School and the University of Oregon, then moved to Colorado where she graduated from Colorado College of Dental Assisting. She returned to Oregon and majored in pre-dental at Oregon State University. She received her dental degree from Oregon Health Sciences University.



Following graduation she had a private practice for 11 years in Jefferson, Oregon which she later sold, and is currently employed with Willamette Dental Group as a Managing Dentist at the Willamette Dental Group in Albany, Oregon.

Dr. Parker enjoys her family, friends and traveling. She is concerned about women's issues, especially domestic violence, and participates in focus groups and other activities to fight domestic violence.

In applying for the position on the Board of Dentistry, she told the Governor's Office, "I am interested in this appointment because I feel strongly that Oregonians should have access to affordable quality dental care and I believe the Board of Dentistry plays a role in achieving that end. I believe my broad range of experience and background in patient care and quality management will compliment and diversify the existing Board of Dentistry membership."

Dr. Parker is married and has three grown children and one grandchild. She and her husband have a vacation home in Florida where they plan to retire one day. ■

BOARD MEMBERS

David Smyth, BS, MS
President
Public Member
Term expires 2008

Darren Huddleston, DMD
Vice-President
Grants Pass
Term expires 2009

Rodney Nichols, DMD
Milwaukie
Term expires 2011

Ronald Short, DMD
Klamath Falls
Term expires 2008

Melissa Grant, DMD
Vancouver/Salem
Term expires 2009

Jill Mason, MPH, RDH
Portland
Term expires 2009

Mary Davidson, BS, RDH, LAP
The Dalles
Term expires 2010

Norman Magnuson, DDS
Eugene
Term expires 2010

Patricia Parker, DMD
Albany
Term expires 2010

QUESTIONS? Call the Board office at 971-673-3200 or e-mail your questions to us at information@oregondentistry.org.

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The PARQ or SOAP note just documents that the informed consent discussion took place. This rule has been in place since 1990 and yet many licensees still end up someplace they don't need to be due to their failure to document properly.

A final key to avoiding an interview by the Board's investigators is to use good communication. Yogi used his yogi-isms to get a point across. We need to communicate carefully and clearly with our patients and then document the discussion. Utilization of visual aids and adjunctive media are always useful. These can be used later to help you defend your discussion with the

Board or in court should the need arise. Many are available including pre-printed booklets, video presentations available on tape or DVD, or Web-based patient education and informed consent programs.

The Board does not look for reasons to discipline or reprimand licensees; the opportunities just keep coming. Some are frivolous, but some are valid failures of us as licensees to communicate or document some of the simplest things. If we remember where we want to go and where we don't want to go, we won't end up someplace else. ■

NEW RULES

The Oregon Board of Dentistry has made some changes to the Administrative Rules that govern the practice of Dentistry and Dental Hygiene since the publication of the last newsletter. The following is a brief synopsis of most of the rule changes that the Board made effective March 1, 2007 and May 1, 2007.

If you would like to see copies of these specific changes, they can be found on the OBD Web site or you can request the most recent copy of the Dental Practice Act, which is dated May 1, 2007, by contacting the OBD office.

OAR 818-001-005 Filing Exception and Arguments to the Board, and **OAR 818-001-0021** Petition for Reconsideration of Rehearing as Condition for Judicial Review, were repealed. Both of these procedures currently can be found in the Administrative Procedures Act so the OBD did not have to duplicate them.

OAR 818-012-0030 Unprofessional Conduct, was amended to include the requirements to release photographs; adds the addiction and depen-

dency or abuse of alcohol, illegal or uncontrolled drugs or mind altering substances; and requires a Dentist or Dental Hygienist to work in a clinic owned by an Oregon licensed Dentist except as described under ORS 679.020 (3) and ORS 680.205 (1)(2).

OAR 818-001-0087 Fees, was amended to create a fee for a Dental Hygiene Restorative Functions Endorsement.

OAR 818-035-0025 Prohibitions, was amended to allow Dental Hygienists to perform restorative functions.

OAR 818-035-0040 Expanded Functions of Dental Hygienists, was amended to require an applicant to submit an application to receive this endorsement.

OAR 818-035-0072 Restorative Functions of Dental Hygienists was adopted to allow Dental Hygienists, under indirect supervision of a dentist, to place and finish direct alloy and direct anterior composite restorations. ■

DISCIPLINARY ACTIONS TAKEN BETWEEN FEBRUARY 1, 2006 AND FEBRUARY 28, 2007

Unacceptable Patient Care ORS 679.140(1)(e)

Case #2006-0029 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that on numerous occasions, a dentist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment, failed to document a diagnosis of recurrent caries and an open crown margin, failed to document a dental justification prior to initiating endodontic therapy, failed to document a diagnosis prior to extracting a tooth, failed to document a dental justification for prescribing a controlled substance, failed to document a diagnosis of periodontal disease, failed to document the use of local anesthetic, failed to document the use of prophylactic antibiotic premedication, failed to pre-medicate a patient where premedication was indicated, and failed to complete an adequate pre-surgical history and physical examination. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded and to complete seven hours of Board approved continuing education in the management of a medically compromised patient and three hours of Board approved continuing education in record keeping.

Case #2006-0034 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document the presence of periodontal disease; failed to document the use of local anesthetic; failed to document the name, amount, and dosages of local anesthetic that was administered; failed to document a dental justification for placing restorations; failed to document the taking of impressions; failed to document a dental justification for preparing teeth for crowns; failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment; and failed to take adequate full mouth radiographs. Aware of his right to a

hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

Case #2005-0145 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that on numerous occasions, a dentist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment; failed to document a dental justification for prescribing controlled substances; failed to document the prescribing of controlled substances; failed to document a dental justification for initiating endodontic therapy; failed to document a dental justification for extracting teeth; failed to document pre-op and post-op vital signs, dosage of nitrous oxide and the patient’s condition upon discharge when administering nitrous oxide; failed to document the dosage of vasoconstrictor when administering local anesthetic; failed to accurately document the amount of controlled substances that were prescribed; failed to complete the Board’s 40 hour continuing education requirement for re-licensure; and made a false statement to the Board. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to pay a \$1,000.00 civil penalty, and to complete a three hour Board approved continuing education course in record keeping and a seven hour Board approved continuing education course in pharmacotherapeutics within 60 days.

Case #2003-0040 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist extracted a tooth without dental justification and failed to obtain informed consent prior to extracting the tooth. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

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DISCIPLINARY ACTIONS (Continued from page 5)

Case #2005-0218 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist on numerous occasions failed to document a dental justification for prescriptions, failed to document the quantity of nitrous oxide and oxygen the Licensee administered, failed to make appropriate discharge entries when administering nitrous oxide, failed to document the name and quantity of a controlled substance that was prescribed, wrote a post-dated prescription for a controlled substance, placed three implant structures that were too short, failed to use a facebow transfer when articulating working casts for construction of fixed prostheses, failed to make occlusal adjustments and establish a physiological VDO before dismissing a patient with newly cemented fixed prostheses, and failed to appropriately refer to a specialist when the treatment failed. Aware of her right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to make a \$42,450.00 restitution payment, and to cease and desist from undertaking full-mouth reconstruction cases until the Licensee completes at least 60 hours of a Board approved hands-on mentoring course in fixed prosthodontics.

Case #2000-0076 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist committed 19 counts of unprofessional conduct and unacceptable patient care. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded and to pay a \$7,500.00 civil penalty.

Case #2005-0137 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist seated a four unit bridge with defective and open margins, failed to diagnose caries in two teeth, and seated a crown with a defective and open margin on a tooth. Aware of his right to a hearing, and wishing to resolve this matter, the Li-

ensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to enroll in the Tucker Gold Study Club within 30 days, and regularly participate in the Tucker Gold Study Club for one year.

Case #2003-0096 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist allowed an unlicensed dental hygienist to provide dental hygiene services. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to provide 20 hours of pro bono Board approved community service within one year.

Case #2002-0007 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment, failed to adequately document an examination and dental justification to support the TMD therapy that was provided, failed to adequately document an examination and dental justification to support the orthodontic therapy that was provided, failed to expose adequate radiographs, placed a crown and inlay with inadequate margins, made an untrue statement to the Board, and failed to complete continuing education in the area of medical emergency management. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to complete 35 hours of Board approved hands-on continuing education in crowns and indirect restorations within one year, to utilize radiographs when appropriate, and to complete three hours of Board approved continuing education in record keeping.

Case #2005-0204 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to refer to the patient’s records before making treatment decisions and confirming treatment needs with a subsequent dentist. Aware of her

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DISCIPLINARY ACTIONS (Continued from page 6)

right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

Case #2002-0112 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to obtain informed consent prior to extracting a tooth and failed to document the name, quantity and strength of the local anesthetic that was administered. The dentist requested a hearing, and following the hearing the Board issued a Final Order in which the Licensee was ordered to be reprimanded and to pay disciplinary costs of \$7,389.85. The dentist filed a Notice of Appeal, and then through negotiations the dentist finally agreed to pay 50% (\$3,694.00) of the hearing costs, to dismiss his request for judicial review, and to accept the remainder of the Final Order.

Case #2006-0152 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment; failed to document the taking of intraoral photographs; failed to document the placement of bridges; failed to document the taking of impressions; failed to document a dental justification for placing a nightguard; failed to document a dental justification for placing restorations; failed to document a dental justification for placing crowns; failed to document a dental justification for administering antibiotics; failed to document a dental justification for administering local anesthesia; failed to document the preparation of teeth, the taking of impressions, and the seating of a bridge; failed to document the recementing of bridges; failed to document doing an examination; failed to document the adjustment of a bridge; failed to document a dental justification for remaking a bridge; failed to document a dental justification for remaking a crown; failed to maintain written work orders for laboratory fabrication of prosthetic appliances; failed to provide prophylactic antibiotic coverage;

and betrayed confidences in the patient-dentist relationship. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to pay a \$1,000.00 civil penalty, to complete 16 hours of continuing education in treating medically compromised patients, and to complete at least three hours of continuing education in record keeping.

Case #2006-0215 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that on numerous occasions, a dentist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment, failed to document a dental justification prior to placing restorations, failed to document a dental justification prior to initiating scaling and root planing, failed to document the name of local anesthesia that was administered, failed to document a dental justification prior to initiating periodontal maintenance, failed to document the name of restorative materials that were used, failed to document a dental justification for prescribing an antibiotic, and failed to document that radiographs were taken. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

Case #2006-0197 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist initiated endodontic therapy in a tooth without consent, initiated endodontic therapy in a tooth without a dental justification, and failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

Case #2005-0085 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to record the dispensing of a controlled

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substance on three occasions, documented an erroneous amount when documented the dispensing of a controlled substance, failed to keep a current and constant controlled substance inventory log, and failed to account for controlled substances purchased by the Licensee. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

Case #2006-0192 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment, fabricated alterations to treatment notes on six occasions, attempted to deceive the Board in reference to the fabricated alterations, failed to document a dental justification for placing restorations, failed to document a dental justification for placing a crown, and certified that the Board’s 40 hour continuing education requirement for re-licensure had been completed when it had not been completed. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to pay a \$5,000.00 civil penalty, and to complete the Board’s 40 hour continuing education requirement.

Case #2006-0200 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment, failed to respond to a request to provide information to the Board, failed to maintain documentation of the 24 hours of continuing education required for licensure renewal, and failed to complete the 24 hours of continuing education required for licensure renewal. Aware of her right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to pay a \$1,000.00 civil penalty, and to submit to

the Board documentation of the completion of the Board’s 24 hour continuing education requirement for the next two renewal periods.

Cases #2005-0228 and #2005-0242 Based on an investigation, the Board issued a Notice of Proposed Licensure Revocation and an Amended Notice of Proposed License Revocation alleging that a dentist failed to diagnose caries and a periapical lesion, failed to document “PARQ” or its equivalent after obtaining the patients’ informed consent, failed to document pre and post-operative vital signs and dosages of gases administered when administering nitrous oxide, failed to document that impressions were taken, failed to document a dental justification prior to providing treatment, failed to document which teeth were treated, failed to document the adjustment of teeth, failed to document the dosages of local anesthetic that were administered, failed to document the dosages of antibiotics that were prescribed, failed to update medical histories, failed to respond to the Board’s requests for information, failed to respond to a subpoena issued by the Board, failed to complete the Board’s 40 hour continuing education requirement for re-licensure, and violated a previous Board Order. Aware of his right to a hearing, the Licensee entered into a Consent Order in which the Licensee agreed to be reprimanded, to complete the Board’s 40 hour continuing education for re-licensure for the past two licensing periods before re-engaging in the practice of dentistry, to enter the Board-OAGD mentoring program before re-engaging in the practice of dentistry, to have the Licensee’s license to practice dentistry suspended for 30 days following the Licensee’s re-engagement into the practice of dentistry, to complete the Board-OAGD mentoring program after re-engaging in the practice of dentistry, and that the provisions of the Licensee’s Amended Consent Order entered into on June 27, 2003 remain in effect.

Case #2007-0004 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist provided conscious sedation without first obtaining a Class 2 Anesthesia Permit, failed to docu-

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DISCIPLINARY ACTIONS (Continued from page 8)

ment pre and post-operative vital signs when administering conscious sedation, failed to obtain written informed consent prior to providing conscious sedation, and failed to place space maintainers due to a patient pursuant to a contract with the patient's guardian. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

Case #2007-0130 Based on the results of an investigation, the Board issued an Order of Immediate Emergency License Suspension based on findings that the Licensee did not perform any spore testing of the Licensee's sterilizing autoclave and used instruments that were processed in the autoclave, and concluded the Licensee poses a serious danger to the public's health and safety.

Case #2002-0273 Based on the results of an investigation, the Board issued an Order of Immediate Emergency License Suspension based on findings that the Licensee did not perform any spore testing of the Licensee's sterilizing autoclave; used instruments that were processed in the autoclave; reused disposable instruments including evacuation tips, disinfection pouches, and irrigation syringes; used unsterile sponge packing material to hold files and reamers; and failed to sterilize dental handpieces between patients, and concluded that the Licensee poses a serious danger to the public's health and safety.

Case #2007-0093 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document with "PARQ" or its equivalent that informed consent had been obtained prior to providing treatment and placed composite restorations in eight teeth without any documented dental justification and where no dental pathology existed. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded and to pay a \$2,500.00 civil penalty.

Case #2006-0243 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist rendered central nervous system sedation without first obtaining the appropriate permit. Aware of her right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded and to pay a \$250.00 civil penalty.

Case #2007-0078 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist prepared a tooth for a crown without any documented dental justification, failed to document that impressions were taken or that a temporary crown was placed, prescribed antibiotics without any documented dental justification, failed to document with "PARQ" or its equivalent that informed consent had been obtained prior to providing treatment, and failed to diagnose and document the separation of an endodontic file that was evident on dental radiographs. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded.

Case #2002-0273 Based on the results of an investigation, the Board issued an Order of Immediate Emergency License Suspension based on findings that the Licensee did not perform any spore testing of the Licensee's sterilizing autoclave; used instruments that were processed in the autoclave; reused disposable instruments including evacuation tips, disinfection pouches, and irrigation syringes; used unsterile sponge packing material to hold files and reamers; failed to sterilize dental handpieces between patients; and concluded that the Licensee poses a serious danger to the public's health and safety. Aware of her right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into an Amended Consent Order in which the Licensee agreed to be reprimanded, to only practice in a group practice, to submit a detailed proposal for practicing in a group practice, to have a restricted

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license for at least six months during which the Licensee will demonstrate clinical competency under the supervision of a Board approved Oregon Licensee with numerous restrictions, to provide 40 hours of community service, to appear before the Board, and to provide a copy of the Amended Consent Order to her employer.

Case #2007-0099 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to document with “PARQ” or its equivalent that informed consent had been obtained prior to providing treatment; failed to document the name, quantity and strength of local anesthetic that was administered; failed to document a dental justification prior to extracting a tooth; prescribed Augmentin to a patient with a penicillin allergy; initiated endodontic therapy without a dental justification; extracted teeth without a documented dental justification; fabricated alterations to treatment notes on six occasions; and certified that the Board’s 40 hour continuing education requirement for re-licensure had been completed when it had not been completed. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded, to pay a \$1,000.00 civil penalty, to complete at least three hours of continuing education in record keeping, to complete 16 hours of Board approved continuing education in the management of a medically compromised patient, and to complete the Board’s 40 hour continuing education requirement.

Case #2006-0233 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist allowed a dental assistant to administer oral conscious sedation agents to a patient, failed to obtain written informed consent prior to providing conscious sedation, failed to start monitoring the patient until approximately one hour had passed from the time the agents were administered, failed to document pre and post-operative vital signs, and failed to document the patient’s condition upon discharge. Aware of his right to

a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to be reprimanded and to provide 20 hours of community service.

Violation of an Order Issued by the Board ORS 679.140(1)(d)

Case #2005-0077 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist failed to pay a \$3,500.00 civil penalty and failed to respond to a written request for information from the Board. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into an Amended Consent Order in which the Licensee agreed to not employ his wife at the physical location of his practice, to not permit his wife to have any access to correspondence from the Board or from the Licensee to the Board, and to appear before the Board.

Unprofessional Conduct ORS 679.140(2)

Case #2006-0035 Based on the results of an investigation, the Board issued an Order of Immediate Emergency License Suspension based on findings that due to the nature and extent of the alcohol and marijuana abuse, a positive urinalysis for Benzodiazepines, and the dentist’s admission that he treated patients while he was under the influence of one or more substances, and concluded the Licensee poses a serious danger to the public health and safety.

Case #1997-0091 Based on the results of an investigation, the Board issued an Order of Immediate Emergency License Suspension based on findings that due to the nature and extent of previous alcohol abuse, the dentist’s admission that she intentionally inhaled chemicals used as propellants, and the arrest for erratic driving while impaired after using inhaled propellants, and concluded the Licensee poses a serious danger to the public health and safety.

Case #2007-0069 Based on the results of an investigation, the Board issued an Order of Immediate Emergency License Suspension based on findings that due to the nature and extent of

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alcohol abuse, an arrest for driving under the influence of alcohol, and treating a patient while he was under the influence of alcohol, and concluded the Licensee poses a serious danger to the public health and safety.

Case #2007-0033 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dentist placed a Yellow Pages advertisement in which the Licensee failed to identify the Licensee as a general dentist in type as large as the type used to offer specific services. Aware of her right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to pay a \$500.00 civil penalty.

Case #2006-0035 Based on the results of an investigation, the Board issued an Order of Immediate Emergency License Suspension based on findings that due to the nature and extent of the alcohol and marijuana abuse, a positive urinalysis for Benzodiazepines, and the dentist's admission that he treated patients while he was under the influence of one or more substances, and concluded the Licensee poses a serious danger to the public health and safety. Aware of his right to a hearing, and wishing to resolve this matter, the Licensee voluntarily entered into a Consent Order in which the Licensee agreed to resign his Oregon dental license and to never reapply for licensure in Oregon.

Applicant Issues ORS 679.060(4)

Case #2006-0022 Based on the results of an investigation into the information provided in an application for a license to practice dental hygiene in which the Applicant provided false information, and failed to provide information, and then failed to respond to a written Board request to provide documentation, the Board determined that legal cause existed to deny the Applicant's application for licensure and issued a Notice of Proposed Denial of Application for License. The Applicant failed to request a hearing in a timely manner so the Board issued a Default Order in

which the license application of the Applicant was denied.

Practicing Dentistry Without a License ORS 679.020

Case #2006-0203 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that between April 1, 2006 and April 30, 2006, a dentist practiced dentistry without a license and engaged in, conducted, operated and maintained a dental office without a license. Aware of his right to a hearing, and in order to resolve this matter, the dentist voluntarily entered into a Consent Order with the Board in which the dentist agreed to pay a \$375.00 civil penalty.

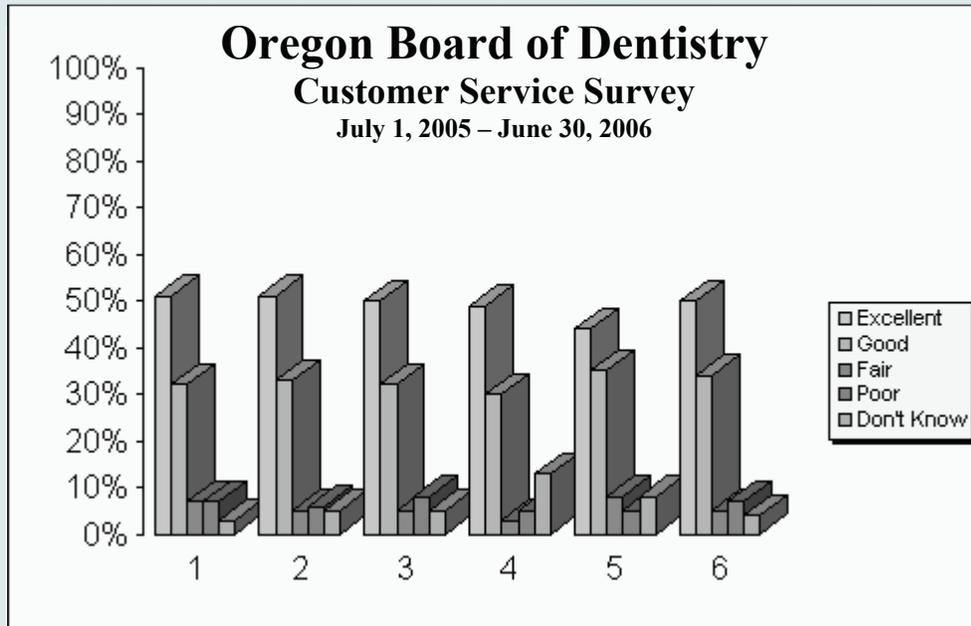
Case #2006-0211 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that between April 1, 2006 and April 30, 2006, a dentist practiced dentistry without a license and engaged in, conducted, operated and maintained a dental office without a license. Aware of his right to a hearing, and in order to resolve this matter, the dentist voluntarily entered into a Consent Order with the Board in which the dentist agreed to pay a \$500.00 civil penalty.

Failure to Complete Continuing Education Required for License Renewal OAR 818-021-0070(1)

Case #2006-0111 Based on the results of an investigation, the Board issued a Notice of Proposed Disciplinary Action alleging that a dental hygienist failed to respond to the Board's written request for information and failed to complete the 24 hours of continuing education for the 2001-2003 and 2003-2005 license renewal periods and failed to maintain records of successful completion of continuing education for at least four licensure years. Aware of her right to a hearing, and in order to resolve this matter, the Licensee entered into a Consent Order with the Board in which the Licensee agreed to be reprimanded, to pay a \$500.00 civil penalty, to complete the 24 hours of continuing education for each of the two licensing periods, and to provide ten hours of community service within 90 days. ■

OREGON BOARD OF DENTISTRY ANNUAL PERFORMANCE PROGRESS REPORT 2006

Performance Measure Definition	2006 Goal	2006 Performance
#1 Percent of Licensees in compliance with continuing education requirements	100%	100%
#2 Average time from receipt of a new complaint to completed investigation (ready to be submitted to the Board)	3.75 months	Cases opened and investigations completed during the period 7/1/2005 through 6/30/2006 (2 months)
#3 Average number of working days from the receipt of completed paperwork to issuance of license (new or renewal)	7 Days	3.5 Days
#4 Agency Overall Satisfaction – Percent of customers rating their overall satisfaction with the agency above average or excellent	Legislative Mandate No Goal Approved during 2005-2007 Biennial Budget	84%
#5 Customer Satisfaction – Percent of customers rating satisfaction with the agency services above average or excellent for A: Timeliness; B: Accuracy; C: Helpfulness; D: Expertise; E: Information Availability	Legislative Mandate No Goal Approved during 2005-2007 Biennial Budget	A: Timeliness – 84% B: Accuracy – 83% C: Helpfulness – 82% D: Expertise – 78% E: Information Availability - 79%



- 1 How do you rate the timeliness of the services provided by the OBD?
E= 51% G= 32% F= 7% P= 7% DK= 3%
- 2 How do you rate the ability of the OBD to provide services correctly the first time?
E= 51% G= 33% F= 5% P= 6% DK= 5%
- 3 How do you rate the helpfulness of the OBD?
E= 50% G= 32% F= 5% P= 8% DK= 5%
- 4 How do you rate the knowledge and expertise of the OBD?
E= 49% G= 30% F= 3% P= 5% DK= 13%
- 5 How do you rate the availability of information at the OBD?
E= 44% G= 35% F= 8% P= 5% DK= 8%
- 6 How do you rate the overall quality of services provided by the OBD?
E= 50% G= 34% F= 5% P= 7% DK= 4%

LICENSE RENEWAL

Every year the OBD sends out approximately 1,800 Dental and 1,700 Dental Hygiene renewal notices. This is approximately one-half of the licensed Dentists and Dental Hygienists licensed in the state.

Dental renewal notices are mailed in January of the year that they expire and the expiration date is March 31 of that year. Dental Hygiene renewal notices are mailed in July of the year that they expire and the expiration date is September 30 of that year.

In order for Dentists and Dental Hygienists to be able to practice, they need to have renewed their license. The completed renewal form and appropriate fees must be received at the Board office at least 10 working days before the expiration date. The Board cannot guarantee that a license will be renewed by the expiration date if it arrives during the 10 working days before the expiration date.

IF WE HAVE NOT RENEWED YOUR LICENSE BY THE EXPIRATION DATE, AND YOU CONTINUE TO PRACTICE, YOU ARE PRACTICING ILLEGALLY AND CAN BE SUBJECT TO DISCIPLINARY ACTION BY THE BOARD. PRACTICING WITHOUT AN ACTIVE LICENSE IS A VERY SERIOUS MATTER.

Our license look-up system found on our Web site at www.oregon.gov/Dentistry is updated daily to reflect all renewed licenses. To save you time, you can access the status of your license 24/7. If the information shows that your license has not been renewed, this means that we have not received your completed renewal, it has not been processed or it is being returned to you as it was incomplete.

The Board has worked very hard to keep the costs of operating the Board to be within the budget that has been approved by the Legislature and fees have not been raised since 1999.

However, this is becoming more and more difficult. Approximately 10% of the renewal notices are returned to the Board office, which requires the staff to find new addresses and remail them, which increases staff costs; not to mention the additional postage. All Licensees are required to notify us of an address change within 30 days of that change and our Web site has an address change form that can be e-mailed directly to the Board, to make it easier for Licensees.

Also, at least another 15% of the Licensee renewal forms are sent to the office and are incomplete and they must be returned to the Licensee for completion.

All Licensees are encouraged to review the new license that they receive in the mail to see that everything is correct on that license. If your previous license has a notation of an endorsement or permit and the new license does not have this, then this means that the Board has not renewed that endorsement or permit and if that is incorrect, you need to notify the Board. Simply thinking that you had an active permit or endorsement in the last renewal cycle, does not mean that you have the same endorsement or permit in this cycle.

Finally, a license renewal is the Licensee's responsibility!!!! It is not your office manager's, spouse's, or accountant's responsibility to complete this renewal form. Do not pass the completion of this very important renewal form to anyone but yourself. ■

Congratulations to Richard A. Guerra, DDS, of Coronado, California. He was the first dentist to renew his license during the last renewal cycle. License renewal applications were mailed January 12, 2007 and we received his application and fee on January 17, 2007.

A job well done, Dr. Guerra!

ASK THE BOARD

Can a certified Emergency Medical Technician (EMT) start an IV line using their EMT certification alone, but acting as a dental assistant when they do the task?

The short answer is no.

ORS Chapter 682 governs EMTs generally. According to the rules that govern the EMTs (OAR 847-035-0030), an EMT Intermediate certificate holder can insert an IV Line; an EMT Basic cannot.

In the EMT scope of practice, that same rule requires that no EMT may function without assigned standing orders issued by a Board approved supervising physician. EMTs are supervised directly by a supervising physician and they give those standing orders depending on the EMT's education and experience.

EMTs either have to have standing orders from a supervising physician, or get direct permission from the supervising physician to insert an IV line.

The supervising physician is defined in rule as "a person licensed under ORS Chapter 677, actively registered and in good standing with the Board as a Medical Doctor or Doctor of Osteopathic Medicine..." It does not include "dentist" in that definition.

So if a Dental Assistant without the Certified Anesthesia Dental Assistant Certificate is also an EMT and wants to start an IV line, they would have to have standing orders from a licensed physician. A dentist does not qualify as a licensed physician.

If you have a question you would like to ask the Board, please feel free to e-mail that question to information@oregondentistry.org. We will print the questions and answers in a future newsletter. ■

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The Board office is open from 7:30 a.m. to 4:30 p.m. Monday through Friday except State and Federal holidays.
Phone: 971-673-3200 Fax: 971-673-3202

SCHEDULED BOARD MEETINGS

2007-2008

- July 13, 2007
- September 14, 2007
- November 9, 2007
- January 4, 2008
- February 29, 2008
- April 25, 2008
- June 20, 2008
- August 15, 2008
- October 10, 2008
- December 5, 2008



Licensees are required to report any change of address within 30 days.

CHANGE OF ADDRESS FORM

Licensee Name: _____
Print Name *Phone*

License Number: _____

New Mailing Address: _____

Above is: Home Address Office Address

Mail or Fax to: **OREGON BOARD OF DENTISTRY**
1600 SW 4th Avenue, Suite 770
Portland, OR 97201-5519
Phone: (971) 673-3200
Fax: (971) 673-3202